

FIG. 1

Title: \_\_\_\_\_

PROCESSING AN INSURANCE CLAIM USING  
ELECTRONIC VERSIONS OF SUPPORTING DOCUMENTS

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Docket No.: 14689.12

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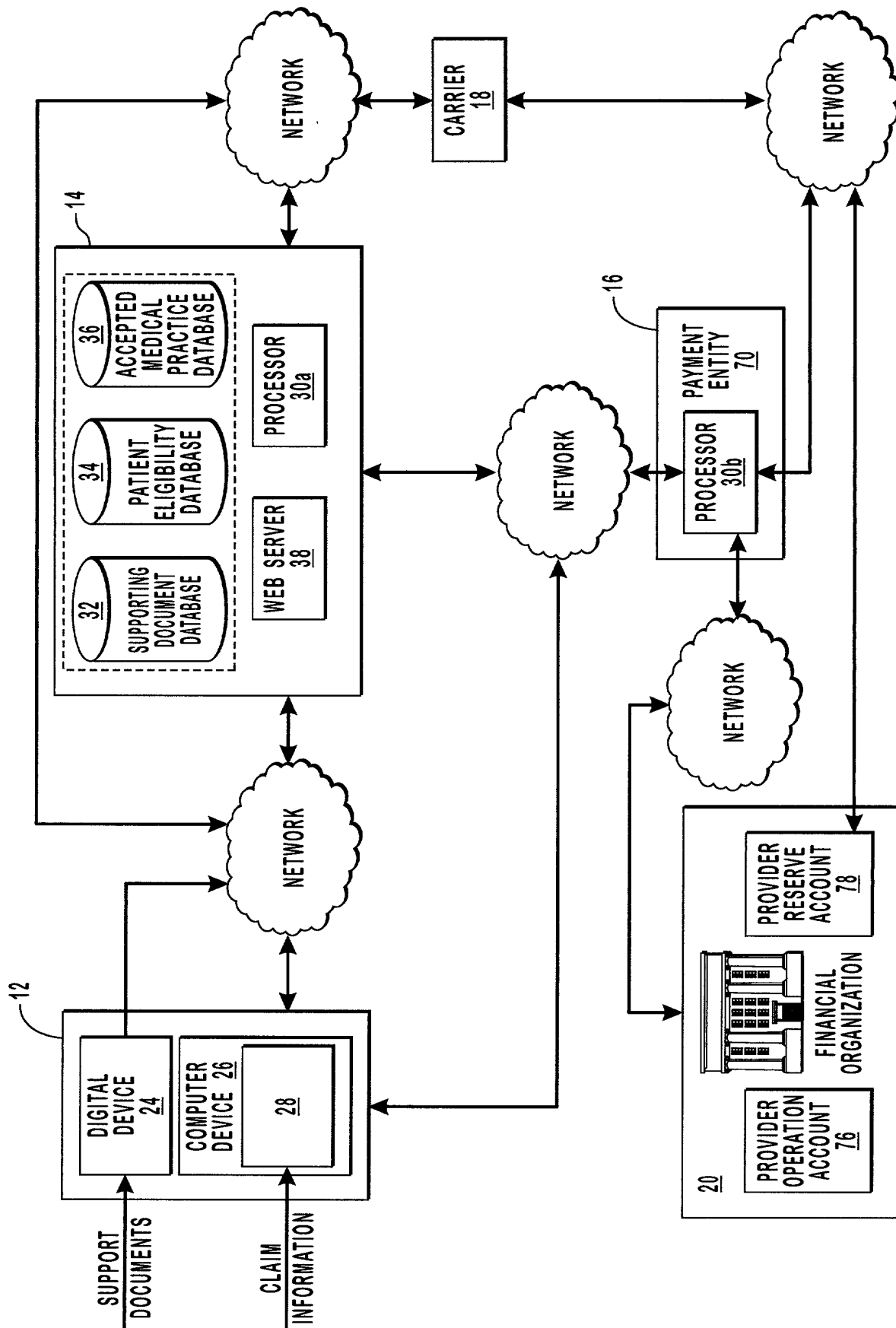


FIG. 2

Health Care Claims Form

Plan I D	
Insured's I D	
Paitent's date of birth	- mm/dd/yy
Provider I D	

FIG. 3

**FIG. 5**

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## Health Care Claims Form

Plan ID : 1234

Insured : Doe, John 541XXXXX

Patient : 01, Jane

Provider: MISCELLANEOUS PROVIDERS

Please enter the Patient Dependent Number from above from above: 56

Last Name, First, Middle Initial, I.D.

Referring Physician

Service Provider

Diagnosis or Nature of Illness or Injury.

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Dates of Service		Place	Type	Procedure, Service or Supplies				
From	To	Svc	Svc	CPT	Modifier	Diagnosis No	\$Charges	
					54		60	

Patient's Account	Accept Assign?	Total Charge	62
	Yes <input type="radio"/> No <input type="radio"/>	Amount Paid	58
		Balance Due	64

FIG. 4

Variable	Mean	SD	Min	Max
Age	38.5	12.5	18	65
Gender	0.5	0.5	0	1
Marital status	0.5	0.5	0	1
Education	12.5	2.5	9	16
Income	15.5	10.5	5	35
Health status	1.5	1.5	1	3
Stress level	2.5	1.5	1	4
Life satisfaction	3.5	1.5	1	5
Work satisfaction	3.5	1.5	1	5
Family satisfaction	3.5	1.5	1	5
Community satisfaction	3.5	1.5	1	5
Overall satisfaction	3.5	1.5	1	5

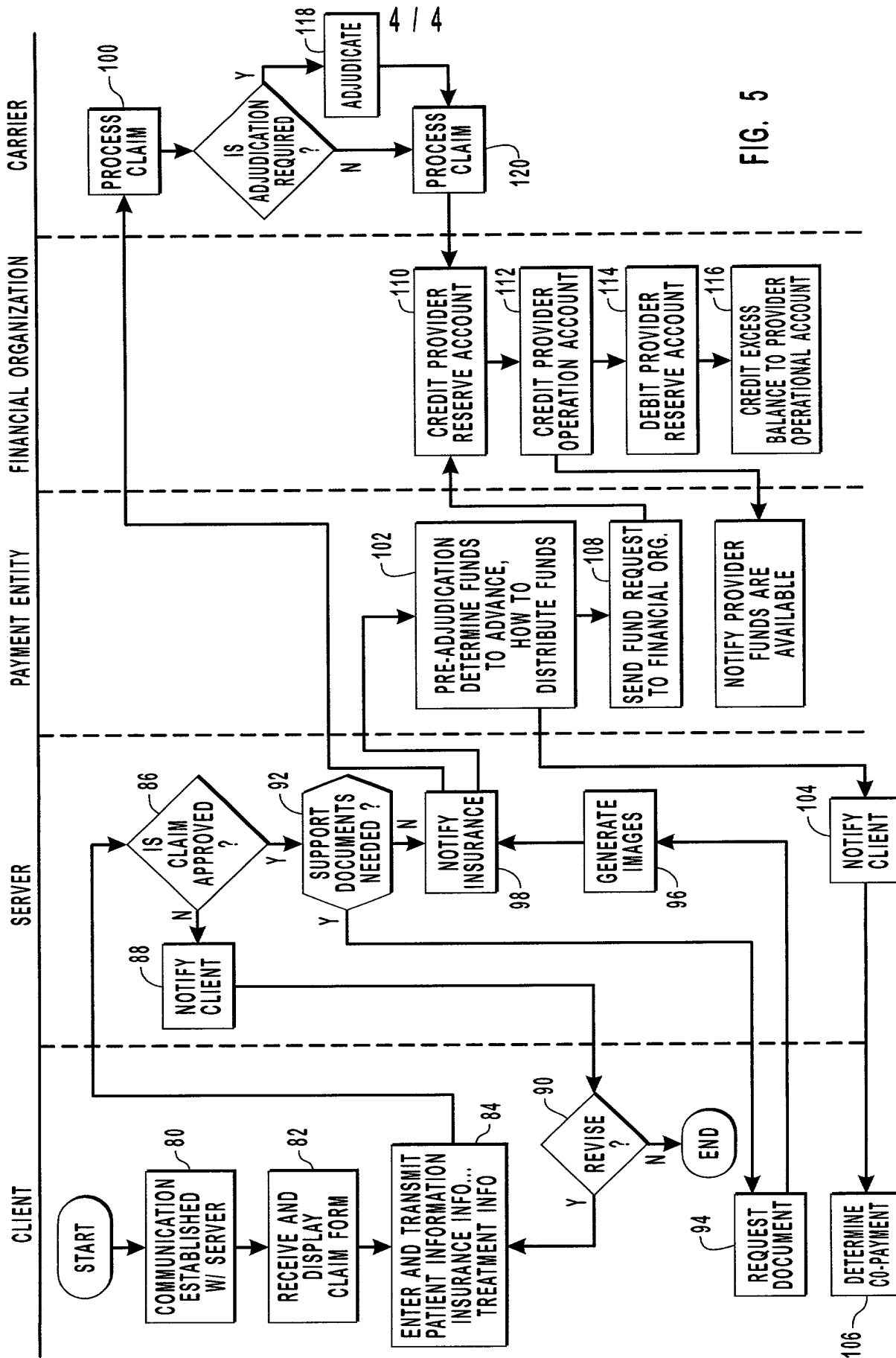


FIG. 5